

**READ THIS FIRST****USE THESE INSTRUCTIONS TO HELP YOU FILL OUT  
THE ATTACHED MEDI-CAL ANNUAL REDETERMINATION FORM  
(Please return this form to your county welfare department)**

1. **PRINT** all answers in ink (black ink is best).
2. Please note the following:
  - “Applicant”** means: (a) you, if you are applying for yourself and/or your family; or (b) the person you are filling in this form for (including the person in long-term care).
  - “Caretaker”** means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children’s Medi-Cal case.
  - “Family Member”** means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse’s or other parent’s children under 21 years, who are living with you or are away at school; (e) your unborn child.
3. If you need help or have any questions, **ask your worker.**
4. If you need more space to answer any question, or have additional information to report, use **question 21.**

MC 210 RV (8/99) INSTRUCTION SHEET

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# MEDI-CAL ANNUAL REDETERMINATION

Do you want your Medi-Cal benefits to continue? ☐ YES ☐ NO If no, sign and date the last page of this form.  
If yes, you must answer all of the following questions.

ADULT FAMILY MEMBERS	1 Applicant or Caretaker's Name (First, Middle, Last)				Applicant/Caretaker Relationship to Children				<b>COUNTY USE ONLY</b>  Case name: _____  Case Number: _____  Worker Number: _____  Date: _____												
	Social Security Number		Marital Status (check one) <input type="checkbox"/> Married (Date) _____ <input type="checkbox"/> Never married <input type="checkbox"/> Common law <input type="checkbox"/> Separated (Date) _____ <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male																
	Is Person Working? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the Person Blind, Disabled or Incapacitated? <input type="checkbox"/> Yes, Date of Disability: _____ <input type="checkbox"/> No		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No		Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No														
	2 Home Address (Number and Street)		City		ZIP Code																
	Mailing Address (If different from above)		City		ZIP Code																
	Area Code and Home Phone ( )		Area Code and Work Phone ( )		Area Code and Message Phone ( )		Person With Whom to Leave Message:														
CHILDREN AND OTHER ADULTS IN HOUSEHOLD	3 Spouse/Other Parent (First, Middle, Last)				Relationship to Applicant																
	Social Security Number		Marital Status (check one) <input type="checkbox"/> Married (Date) _____ <input type="checkbox"/> Never married <input type="checkbox"/> Common law <input type="checkbox"/> Separated (Date) _____ <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male																
	Is Person Working? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the Person Blind, Disabled or Incapacitated? <input type="checkbox"/> Yes, Date of Disability: _____ <input type="checkbox"/> No		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No		Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No														
	4 LIST ALL CHILDREN AND OTHER ADULTS LIVING IN YOUR HOUSEHOLD:																				
LIVING ARRANGEMENT IN-KIND	5 Do you or any family member:																				
	a. Pay for an apartment or house? Amount \$ _____ <input type="checkbox"/> Yes <input type="checkbox"/> No																				
	b. Get free housing, utilities, food, or clothing? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No																				
	c. Work in exchange for housing, utilities, food, or clothing? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No																				
If b or c are "yes," answer all the following questions:																					
<table border="1"> <thead> <tr> <th>What was received?</th> <th>Who received it?</th> <th>Who provided it?</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>										What was received?	Who received it?	Who provided it?									
What was received?	Who received it?	Who provided it?																			
TAX DEPENDENT	6 Are you or any family member claimed as a tax dependent by a person not living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
	Name and address of person claiming the tax deduction: _____ _____																				
RESIDENCY	7 Has anyone changed immigration/citizenship status in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
Who: _____ Alien number: _____ What changed: _____ Date: _____																					
DED	8 Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
Who: _____ <input type="checkbox"/> DED packet <input type="checkbox"/> DED Re-exam date _____																					
HEALTH INSURANCE	9 Do you or any family member have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
Who is insured? _____ Did you or any family member get new health, dental, or Medicare coverage or insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
<input type="checkbox"/> DHS 6155 form given																					

<b>EMPLOYMENT</b>	<b>10</b> Attach a copy of the three most recent wage stubs for each person who is working. Person Number 1—Name _____					Gross Monthly Earnings \$ _____		<b>COUNTY USE ONLY</b>		
	Employer _____			Work Telephone (     ) _____		Date Employment Began (If New Job) ____ / ____ / ____		<input type="checkbox"/> Wage Stubs		
	Address (Number and Street) _____			City _____		State _____		ZIP Code _____ <input type="checkbox"/> If U-Parent, MC 210 SW		
	Hours Worked Per Week _____		Hours Worked Per Month _____		<input type="checkbox"/> Paid Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Two Times a Month <input type="checkbox"/> Other		Income From Tips \$ _____ <input type="checkbox"/> Student exemption			
	Person Number 2—Name _____					Gross Monthly Earnings \$ _____				
	Employer _____			Work Telephone (     ) _____		Date Employment Began (If New Job) ____ / ____ / ____		<input type="checkbox"/> Wage Stubs		
	Address (Number and Street) _____			City _____		State _____		ZIP Code _____ <input type="checkbox"/> If U-Parent, MC 210 SW		
	Hours Worked Per Week _____		Hours Worked Per Month _____		<input type="checkbox"/> Paid Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Two Times a Month <input type="checkbox"/> Other		Income From Tips \$ _____ <input type="checkbox"/> Student exemption			
	Person Number 3—Name _____					Gross Monthly Earnings \$ _____				
	Employer _____			Work Telephone (     ) _____		Date Employment Began (If New Job) ____ / ____ / ____		<input type="checkbox"/> Wage Stubs		
Address (Number and Street) _____			City _____		State _____		ZIP Code _____ <input type="checkbox"/> If U-Parent, MC 210 SW			
Hours Worked Per Week _____		Hours Worked Per Month _____		<input type="checkbox"/> Paid Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Two Times a Month <input type="checkbox"/> Other		Income From Tips \$ _____ <input type="checkbox"/> Student exemption				
<b>BUSINESS</b>	<b>11</b> If any family member is self-employed, attach a copy of last federal tax return or profit/loss statement. Adjusted gross income from last federal tax return: \$ _____ Has income changed? <input type="checkbox"/> Yes <input type="checkbox"/> No							<input type="checkbox"/> Profit/loss statement		
	<b>12</b> a. Business/self employment checking/savings accounts or cash? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Business equipment, vehicles, tools, inventory, or materials (including livestock or poultry not for personal use): _____ \$ _____ c. Type of equipment: _____							\$ _____ \$ _____		
<b>OTHER INCOME</b>	<b>13</b> Do you, the other parent/spouse, or children living in the home receive any other income? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the source and amount of income received each month. If income is received less often than monthly, indicate how often received. Attach proof of this income.							<input type="checkbox"/> Verifications <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent		
	<b>Source of Income</b>		<b>Applicant</b>		<b>Spouse</b>		<b>Child</b>			
	Social Security or Railroad Retirement		\$ _____		\$ _____		\$ _____			
	SSI/SSP		\$ _____		\$ _____		\$ _____			
	Veterans Benefits (including Aid and Attendance payments)		\$ _____		\$ _____		\$ _____			
	Retirement or Pension		\$ _____		\$ _____		\$ _____			
	Interest Income or Dividends		\$ _____		\$ _____		\$ _____			
	Contributions (including those from relatives)		\$ _____		\$ _____		\$ _____			
	Child and Spousal Support		\$ _____		\$ _____		\$ _____			
	Unemployment		\$ _____		\$ _____		\$ _____			
	State Disability		\$ _____		\$ _____		\$ _____			
	Worker's Compensation		\$ _____		\$ _____		\$ _____			
	CalWORKS		\$ _____		\$ _____		\$ _____			
	Other (describe)		\$ _____		\$ _____		\$ _____			
	<b>OTHER EXPENSES</b>	<b>14</b> Does anyone who works pay for care of a child or disabled adult? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following (attach receipts):								<input type="checkbox"/> Receipts
<b>Name of Person Receiving Care</b>		<b>Age of Person Receiving Care</b>		<b>Amount of Payment</b>		<b>How Often Paid</b>				
Person 1										
Person 2										
Person 3										
Who do you pay for the care? _____ Name _____ Address _____										
<b>OTHER EXPENSES</b>	<b>15</b> Does anyone pay court-ordered child or spousal support? <input type="checkbox"/> Yes <input type="checkbox"/> No   Amount \$ _____							<input type="checkbox"/> Court order <input type="checkbox"/> Verified actual payment		
	<b>16</b> Is anyone receiving school grants or loans? <input type="checkbox"/> Yes <input type="checkbox"/> No   Who? _____							<input type="checkbox"/> MC 210 SE		

<b>LIQUID RESOURCES</b>	<b>17</b>	List all resources you, the other parent/spouse, or children living in the home have, or resources held or kept for you by anyone. a. Cash or uncashed checks: Amount \$ _____ b. List all savings or checking accounts in banks, savings and loans, credit unions, IRA, KEOGH, deferred compensation, retirement accounts, annuities, stocks, bonds, certificates of deposit, or money market or mutual fund accounts: <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;">Financial Institution</th> <th style="width:20%;">Type of Account</th> <th style="width:20%;">Account Number</th> <th style="width:30%;">Value/Balance</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>	Financial Institution	Type of Account	Account Number	Value/Balance																	<b>COUNTY USE ONLY</b>									
	Financial Institution	Type of Account	Account Number	Value/Balance																												
				<input type="checkbox"/> Copies of accounts																												
<b>REAL AND PERSONAL PROPERTY</b>	<b>18</b>	a. List real property you own in any country, state, or county (land you own, have title to, or share title in). ITEMS: houses, land, apartments, mobile homes taxed as real property, or other. If new property, attach a copy of escrow papers and tax statement. Address or description of property: _____ _____ Value of new property: \$ _____ Amount owed: \$ _____ Monthly payment: \$ _____ b. Address or description of property that you no longer own: _____ Did you sell this property? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: when? _____ Value of property sold \$ _____ Did you give this property to someone? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: who did you give it to? _____ If you sold or gave away property, attach proof. c. List all life insurance policies, burial plans, burial plots, crypts, or vaults: _____ _____ Face value of any life insurance policies, burial plans, burial plots, crypts, or vaults: \$ _____		<input type="checkbox"/> Exempt? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Escrow papers   <input type="checkbox"/> Sold <input type="checkbox"/> Given away   <input type="checkbox"/> CSV																												
		19 List all cars, trucks, campers, motor homes, motorcycles, airplanes, boats, trailers, or off-road vehicles (even if not running) owned by you or your family. Attach copies of vehicle registrations. If none, write "none." <table style="width:100%; border-collapse: collapse;"> <tr> <th rowspan="2" style="width:20%;">Make and Model</th> <th rowspan="2" style="width:10%;">VIN</th> <th rowspan="2" style="width:10%;">Year</th> <th rowspan="2" style="width:15%;">Owner</th> <th rowspan="2" style="width:15%;">Amount Owed</th> <th colspan="2" style="width:20%;">Used for Transportation?</th> </tr> <tr> <th>Yes</th> <th>No</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>		Make and Model	VIN	Year	Owner	Amount Owed	Used for Transportation?		Yes	No																				
Make and Model	VIN	Year	Owner						Amount Owed	Used for Transportation?																						
				Yes	No																											
<b>SERVICES</b>	<b>20</b>	a. Do you want information for Child Health and Disability Prevention Program (CHDP) health services for children under 21? <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div> b. Do you want information on the special supplemental program for Women, Infants, and Children (WIC) for pregnant or breastfeeding women and children under 5? <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>		<input type="checkbox"/> CHDP brochure/referral  <input type="checkbox"/> WIC referral																												
<b>ADDITIONAL INFORMATION</b>	<b>21</b>	Additional information: (List any additional information for questions 1 through 20.) _____ _____ _____ _____																														

#### CERTIFICATION

- I have read and received a copy of the Important Information for Persons Requesting Medi-Cal form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and/or any family members if I/we claim to be in a satisfactory immigration status. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/our family's eligibility and share-of-cost level, if any, are correct.

**It is the responsibility of the applicant/beneficiary and person acting for the applicant/beneficiary to report to the Eligibility Worker within ten (10) days any changes that occur.**

**I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Statement of Facts and any of its supplemental form(s) that I may be asked to complete is true and correct.**

Signature of Applicant		Date
Signature of Witness, Interpreter, or Person Assisting	Telephone Number (     )	Date
EW Signature		Date